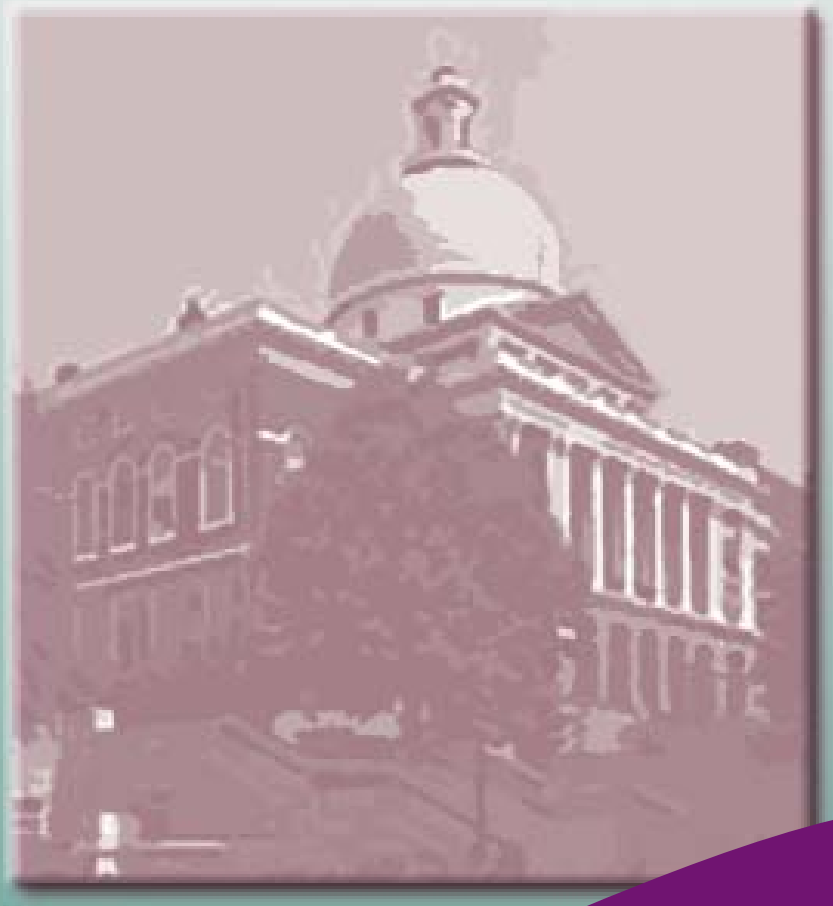
Commonwealth
INDEMNITY PLAN PLUS
The PLUS Plan
Benefit Updates and Important Information



SERIES 4
EFFECTIVE
JULY 1, 2006

Commonwealth of Massachusetts
Group Insurance Commission

UniCare®

Updates to the Commonwealth Indemnity Plan PLUS Member Handbook

This booklet contains important updates to your Commonwealth Indemnity Plan PLUS (the PLUS Plan) coverage effective July 1, 2006. Please keep this year's benefit update—together with the Series 4 Member Handbook and the 2004 and 2005 Series 4 benefit updates—in a convenient place for easy access when you need to refer to your health plan information.

If you have any questions about these changes, please call the Commonwealth Service Center at **(800) 442-9300**, Monday through Thursday from 8:30 a.m. to 6:00 p.m., and Friday from 8:30 a.m. to 5:00 p.m. If you are deaf or hard of hearing and have a TDD machine, contact us on our TDD lines at (800) 322-9161 or (978) 474-5163. A customer service representative will be happy to help you.

This benefit update has also been added to the Plan's web site: **www.unicare-cip.com**. This updated information will be included in the next **printed** revision of the Member Handbook.

Note: The page references in this document refer to Member Handbook pages, unless otherwise specified.

Benefit Changes

Family Calendar Year Deductible

A. The chart in the Your Costs section on page 6 of the Series 4 Member Handbook, and on page 5 of the 2005 Series 4 benefit update, is deleted and replaced with the following:

Deductibles
A deductible is a fixed dollar amount you pay for certain services before the Plan begins paying benefits for you or for your covered dependent. The deductible amounts you must satisfy are shown in the chart below.

Deductibles	When You Use a PLUS Provider	When You Use a Non-PLUS Provider
Individual Calendar Year Deductible	None	$100
Family Calendar Year Deductible	None	$200
Inpatient Hospital Quarterly Deductible	Tier 1: $200 Tier 2: $400	$400
Outpatient Surgery Quarterly Deductible	$75	$75

B. The text under "Family Calendar Year Deductible" in the Your Costs section on page 7 of the Series 4 Member Handbook is deleted and replaced with the following:

Family Calendar Year Deductible
If you have family coverage and use non-PLUS providers, $200 in deductibles will apply to your family in any calendar year. There is no family calendar year deductible when you use PLUS providers.

For Example: You, your spouse and your three children have family coverage under the PLUS Plan. You and two of your children go to non-PLUS providers for medical care in January. Two of you pay $75 deductibles and one of you pays a $50 deductible. Even though no one in the family has met the $100 individual deductible, because the family deductible of $200 has been met, no additional calendar year deductible will apply to charges for your family.

Physician Office Visit Copayments

Effective July 1, 2006, the PLUS Plan has tiered copayments ("copays") for physician office visits. You pay a $10 copay for visits to PLUS Tier 1 physicians—both primary care doctors and specialists—and a $20 copay for visits to PLUS Tier 2 physicians or any other physician. Tier 1 physicians were designated as such because they meet our quality and efficiency standards. *Please note that physician tiering does not apply to visits to chiropractors, physical therapists or occupational therapists—these copays remain $15.*

This change to tiered copays for physician office visits is reflected in the Series 4 Member Handbook as follows:

A. The first bulleted item under "How to Receive the Highest Level of Benefits from Your Medical Plan" on page 3 of the Series 4 Member Handbook is deleted and replaced with the following:

- Use PLUS providers for hospital and physician services. For a comparison of benefits when you use PLUS providers versus non-PLUS providers, please refer to the Benefit Highlights section. To save the most on out-of-pocket costs for physician office visits and inpatient hospital care, use PLUS Tier 1 physicians and PLUS Tier 1 hospitals. For a list of PLUS Tier 1 and Tier 2 physicians and hospitals:
  - check the online PLUS Provider Directory at **www.unicare-cip.com** (click on "Provider Search")
  - check the printed version of the PLUS Provider Directory
  - call the Commonwealth Service Center at (800) 442-9300 and a customer service representative will check for you

You will also find a list of PLUS Tier 1 and Tier 2 hospitals in Appendix E on page 16 of this update.

B. The subsection "Copayments" in the Your Costs section on pages 7-8 of the Series 4 Member Handbook is deleted and replaced with the following:

Copayments

A copayment ("copay") is a fixed dollar amount you pay to a provider at the time of service. Copay amounts vary depending on the type of service you receive and whether you use PLUS Tier 1 or Tier 2 physicians and hospitals. They are always deducted before the individual calendar year deductible is applied. Copays do not count toward satisfying deductibles, coinsurance amounts or out-of-pocket maximums.

For example: If you are a member of the PLUS Plan and you or a covered dependent go to a physician's or chiropractor's office, you or your dependent will pay an office visit copay at the time of the visit. Although you usually pay the copay at the time of the visit, you can also wait until the provider bills you.

Another example of a copay you may owe is the $50 copay every time you go to the emergency room. This copay is waived if you are admitted to the hospital. However, if you are admitted to the hospital, the inpatient hospital quarterly deductible applies.

C. The coverage for physician services in the Benefit Highlights section on page 30 of the Series 4 Member Handbook is deleted and replaced with the following:

	When you use a PLUS Provider	When you use a Non-PLUS Provider
Physician Services		🕮 **Also see page 40**
Non-Emergency Treatment at Home, Office or Outpatient Hospital	100% after a $10/20[1] copay per visit. The copay does not count toward the out-of-pocket maximum.	80% after a $10/20[1] copay per visit and after the calendar year deductible. The copay does not count toward the calendar year deductible or the out-of-pocket maximum.
Hospital Inpatient	100%	80%
Emergency Treatment	100%	100%
☎ Chiropractic Care or Treatment	80% after a $15 copay per visit; maximum benefit of $40 per visit, 20 visits per calendar year. The copay and the 20% coinsurance amount do not count toward the out-of-pocket maximum.	80% after a $15 copay per visit and after the calendar year deductible; maximum benefit of $40 per visit, 20 visits per calendar year. The copay and the 20% coinsurance amount do not count toward the calendar year deductible or the out-of-pocket maximum.

D. Footnote 1 in the Benefit Highlights section on page 30 of the Series 4 Member Handbook is deleted and replaced with the following:

[1] Members pay a $10 office visit copay for PLUS Tier 1 physicians and a $20 office visit copay for all other physicians. Members pay a $15 copay for all visits to chiropractors, physical therapists and occupational therapists.

E. The coverage for preventive care in the Benefit Highlights section on page 31 of the Series 4 Member Handbook is deleted and replaced with the following:

	When you use a PLUS Provider	When you use a Non-PLUS Provider
Preventive Care		🕮 **Also see pages 40-41**
Office Visits *(refer to frequency limits on pages 40-41)*	100% after a $10/20[3] copay per visit. The copay does not count toward the out-of-pocket maximum.	80% after a $10/20[3] copay per visit. The copay does not count toward the calendar year deductible or the out-of-pocket maximum.
Annual Gynecological Visits	100% after a $10/20[3] copay per visit. The copay does not count toward the out-of-pocket maximum.	80% after a $10/20[3] copay per visit. The copay and the 20% coinsurance do not count toward the calendar year deductible or the out-of-pocket maximum.
Immunizations	100%	100%
Laboratory Testing[4]	100%[4]	80%[4]. The 20% coinsurance amount does not count toward the out-of-pocket maximum.

F. The following footnotes are added to the Benefit Highlights section on page 31 of the Series 4 Member Handbook:

[3] Members pay a $10 office visit copay for PLUS Tier 1 physicians and a $20 office visit copay for all other physicians. Members pay a $15 copay for all visits to chiropractors, physical therapists and occupational therapists.

[4] For information on covered preventive laboratory services, see the preventive care schedule on pages 40-41.

G. The coverage for family planning services in the Benefit Highlights section on page 34 of the Series 4 Member Handbook is deleted and replaced with the following:

	When you use a PLUS Provider	When you use a Non-PLUS Provider
Family Planning Services		🕮 **Also see page 38**
Office Visits and Procedures	100% after a $10/20[2] copay per visit	100% after a $10/20[2] copay per visit and after the calendar year deductible

H. The following footnote is added to the Benefit Highlights section on page 34 of the Series 4 Member Handbook:

[2] Members pay a $10 office visit copay for PLUS Tier 1 physicians and a $20 office visit copay for all other physicians. Members pay a $15 copay for all visits to chiropractors, physical therapists and occupational therapists.

Copayments

The 15 office visit copayment maximum has been eliminated; all office visits are now subject to a copayment. The following changes are made to the Series 4 Member Handbook to reflect this change:

A. The subsection "Copayments" on pages 7-8 of the Your Costs section of the Series 4 Member Handbook is deleted and replaced with the information shown under item B of "Physician Office Visit Copayments" on page 4 of this update.

B. The coverage for physician services in the Benefit Highlights section on page 30 of the Series 4 Member Handbook is deleted and replaced with the chart shown under item C of "Physician Office Visit Copayments" on page 4 of this update.

C. Footnote 1 in the Benefit Highlights section on page 30 of the Series 4 Member Handbook is deleted and and replaced with the text shown under item D of "Physician Office Visit Copayments" on page 4 of this update.

Other Inpatient Facilities

The coverage for other inpatient facilities in the Benefit Highlights section on page 27 of the Series 4 Member Handbook is deleted and replaced with the following:

	When you use a PLUS Provider	When you use a Non-PLUS Provider
Other Inpatient Facilities		📖 Also see page 35
• Sub-acute Care Hospital/Facility • Transitional Care Hospital/ Facility • Long-term Care Hospital/Facility • Chronic Disease Hospital/ Facility • Skilled Nursing Facility	80% up to a maximum of 45 days per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% after the calendar year deductible, up to a maximum of 45 days per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum.

Early Intervention Services for Children

The coverage for early intervention services in the Benefit Highlights section on page 32 of the Series 4 Member Handbook is deleted and replaced with the following:

	When you use a PLUS Provider	When you use a Non-PLUS Provider
Early Intervention Services for Children		🕮 **Also see page 38**
Programs Approved by the Department of Public Health	80% up to a maximum benefit of $5,200 per child per calendar year, and a lifetime maximum benefit of $15,600. The 20% coinsurance does not count toward the out-of-pocket maximum.	80% up to a maximum benefit of $5,200 per child per calendar year, and a lifetime maximum benefit of $15,600. The 20% coinsurance does not count toward the out-of-pocket maximum.

Benefit Clarifications

Surgery

The coverage for surgery in the Benefit Highlights section on page 28 of the Series 4 Member Handbook is deleted and replaced with the following:

	When you use a PLUS Provider	When you use a Non-PLUS Provider
☎ **Surgery**		🕮 **Also see page 36**
Inpatient	100%	80%
Outpatient Surgery at a Hospital[2]	100% after the outpatient surgery quarterly deductible	80% after the outpatient surgery quarterly deductible

[2] There is no outpatient surgery quarterly deductible for outpatient surgery performed at a physician's office or at an ambulatory surgical facility.

Preventive Care

A. The chart describing the coverage for preventive care in the Benefit Highlights section on page 31 of the Series 4 Member Handbook is changed to include the preventive care laboratory services benefit. The revised chart and added footnotes are shown under item E in "Physician Office Visit Copayments" on page 5 of this update.

B. Item 24(d) of the Description of Covered Services section on page 41 of the Series 4 Member Handbook is modified to add the following:

- Colonoscopy for routine screening (once every 10 years after age 50)

Exclusions

The following items have been added to the Exclusions section on pages 45-47 of the Series 4 Member Handbook:

- Benefits for the diagnosis, treatment or management of mental health/substance abuse conditions by medical (non-mental health) providers. These benefits are covered when provided by mental health providers (see United Behavioral Health section for coverage details).
- Molding helmets

Limitations

Item 12 in the Limitations section on page 49 of the Series 4 Member Handbook is deleted and replaced with the following:

12. Treatment of Temporomandibular Joint (TMJ) disorder is limited to the initial diagnostic examination, initial testing and medically necessary surgery.

Plan Definitions

The following definition is added to the Plan Definitions section on pages 50-56 of the Series 4 Member Handbook:

"Terminal Illness" – an illness, which, if it runs its course, is associated with a life expectancy of six months or less.

General Provisions

The following wording is added to the description of full-time student coverage in the General Provisions section on page 57 of the Series 4 Member Handbook:

The member is responsible for notifying the Plan of any changes in full-time student status.

Important Plan Information

Do You Have Medical Coverage under Another Health Plan?

If you have medical benefits under another health plan in addition to the Commonwealth Indemnity Plan, **you** need to let us know by completing our "Other Health Insurance" form. This way, we can work with the other health plan to determine which plan has the primary responsibility for providing coverage for each service.

This is called "coordination of benefits." This provision lets members with coverage under another plan use the coverage available to them under **all** health plans in which they are enrolled.

You must also complete the Other Health Insurance form if any of your **family members** covered under the Commonwealth Indemnity Plan also have medical benefits under another health plan.

Important: **You do not have to complete the Other Health Insurance form if you only have health plan coverage under the Commonwealth Indemnity Plan. It is not necessary to tell us about coverage under:**

- MassHealth
- Tricare, or
- other types of coverage such as dental, vision or life insurance plans

How to Get a Copy of the "Other Health Insurance" Form

- ***New*** **Plan Members:** You'll find a copy of this form in your welcome package.
- ***Renewing*** **Plan Members:** You can download this form from our web site at **www.unicare-cip.com** by clicking on the link for "Other Health Insurance Form" on the Forms and Documents web page. Or call us at **(800) 442-9300** to request the form.

Need Help?

If you're not sure whether you need to complete the Other Health Insurance form, a customer service representative can help you. Please call **(800) 442-9300**.

Resources Available on the Plan's Web Site

Member access to the Healthwise® Knowledgebase at **www.unicare-cip.com**, the Plan's web site, has been replaced with access to *Web*MD® Personal Health Manager™. *Web*MD® Personal Health Manager™ provides members with a highly personalized online health experience by bringing together trusted health information, enhanced personalized capabilities and comprehensive health risk assessments—including tracking and reminder tools—to help you better manage your health care and health care decision making. You can tailor the site to your own particular medical background and receive medical information directly related to your conditions and diagnoses. You'll find this resource on our Health Care Resources web page.

The Plan's web site, **www.unicare-cip.com**, offers you an extensive range of Plan-related and general health care information and resources. These resources give you the ability to:

- Check the status of your claims.
- Find out about member discounts on a variety of health-related products and services.
- Access information to help you understand and manage various health conditions and treatment procedures with the Healthcare Advisor™. This resource also provides profiles of health care facilities to help you assess where to best receive care, based on your needs and preferences.
- Visit *Web*MD® Personal Health Manager™ to help you better manage your health care and health care decision making.
- Learn what's being done to improve patient safety in hospitals and how this information may help you select a hospital. Find out the extent to which hospitals in your area have implemented safety initiatives developed by the Leapfrog Group for Patient Safety and how frequently they perform certain procedures.
- Access important Plan information, such as notification requirements.
- View your Member Handbook, benefit updates and detailed descriptions of certain Plan benefits.
- Check our list of Preferred Vendors for durable medical equipment and medical supplies.
- Order Plan materials, e-mail the Plan and more.

Prescription Drug Benefit Plan – *Administered By:*

EXPRESS SCRIPTS®

Effective July 1, 2006

Express Scripts is the pharmacy benefit manager for your prescription drug benefit plan. If you have any questions about your prescription drug benefits, contact Express Scripts toll free at (877) 828-9744 (TDD: (800) 855-2881).

The following information replaces the second paragraph of text as well as the chart located in the Express Scripts section on page 15 of the 2005 Series 4 benefit update:

One of the ways your plan maintains coverage of quality cost-effective medications is a multi-tier copayment pharmacy benefit. Effective July 1, 2006, copayments for omeprazole (generic Prilosec®) will decrease. Copayments will increase for non-preferred brand name drugs purchased through home delivery (mail order). The following chart illustrates your copayment based on the type of prescription you fill and where you get it filled.

Copayment for:	Participating Retail Pharmacy up to a 30-day supply	Home Delivery (Mail Order) up to a 90-day supply
Tier 1: Generic Drugs All generic drugs *except:* • omeprazole *(acid reducer)* • Value Tier generics • Also covered: Prilosec OTC®*(28-day supply – retail; 84-day supply – mail)**	$7	$14
Tier 2: Preferred Brand Name Drugs All preferred brand name drugs *and:* • omeprazole *(acid reducer)*	$20	$40
Tier 3: Non-Preferred Brand Name Drugs All non-preferred brand name drugs *including:* • COX-2 inhibitors *(pain and inflammation – Celebrex®)* • Brand name proton pump inhibitors *(acid reducers – currently Aciphex®, Nexium®, Prilosec®, Prevacid®, Protonix®)*	$40	$90
Value Tier • Generic statin *(cholesterol lowering – lovastatin)* • Generic H-2 antagonists *(acid blockers – cimetidine 300, 400 and 800mg; famotidine 40mg; nizatidine 150 and 300mg; ranitidine 300mg)*	$2	$4

** Due to manufacturer packaging*

United Behavioral Health

Mental Health, Substance Abuse and Enrollee Assistance Programs

Effective July 1, 2006

The following information is provided as a clarification to the information found in your Series 4 Member Handbook. This benefit update is effective as of July 1, 2006.

As a reminder, your Member Handbook and benefit update clarifications provide you with a "Description of Benefits" for your mental health, substance abuse and EAP services. While it is a full description of the available benefits under this plan, it is not the "Evidence of Coverage," the legal policy document that UBH submits to the Massachusetts Division of Insurance (DOI). The "Evidence of Coverage" governs the plan and includes state and federal mandated language, required disclosures to the Office of Patient Protection, continuation of coverage provisions as directed by state and federal law, and other required plan disclosures. The full "Evidence of Coverage" is available in electronic form and can be downloaded from the UBH website: **www.liveandworkwell.com** (access code: 10910). If you would prefer a paper copy of this document, please send a written request to UBH at the address provided on page 77 of the Series 4 Member Handbook, and a copy will be sent to you free of charge.

Part II – Benefit Chart: Outpatient Care

The **Outpatient Care** benefits chart found on page 83 of the Series 4 Member Handbook is deleted and replaced in its entirety with the following summary chart. Be sure to read Part III (pages 84-89 of the Series 4 Member Handbook), which describes your benefits in detail and notes some important restrictions.

Outpatient Care (a): Covered Service	Network Benefits	Out-of-Network Benefits
Individual and family therapy	100%, after $15 per visit	First 15 visits: 80% of *allowed charges*
Medication Management: 15-30 minute psychiatrist visit	100%, after $10 per visit	Visits 16 and over: 50% of *allowed charges* (c)
Group Therapy	100%, after $10 per visit	
	Network costs paid by member count towards *out-of-pocket maximum*	Out-of-network care utilized to satisfy the annual deductible counts toward the first 15 visits. Out-of-network costs paid by member do not count toward *out-of-pocket maximum*
Enrollee Assistance Program	Up to 3 visits: 100%	No Coverage for EAP

Outpatient Care (a): Covered Service	Network Benefits	Out-of-Network Benefits
In-Home Mental Health Care	Full Coverage	First 15 visits: 80% of *allowed charges* Visits 16 and over: 50% of *allowed charges* (c)
Drug Testing (as an adjunct to Substance Abuse Testing)	Full Coverage	No Coverage
Provider Eligibility – provider must be an independently licensed mental health professional in one of these disciplines.	MD Psychiatrist, PhD, EdD, MSW, MSN, LICSW, RNMSCS, MA (b)	MD Psychiatrist, PhD, EdD, MSW, MSN, LICSW, RNMSCS, MA (b)

(a) Treatment that is not *precertified* receives out-of-network reimbursement.

(b) Massachusetts independently licensed providers; psychiatrists, psychologists, licensed clinical social workers, psychiatric nurse clinical specialists and allied health professionals.

(c) Out-of-Network outpatient visits 16 and over are subject to the same precertification requirements as Network benefits in order to be eligible for coverage.

Part III – Benefits Explained

The **Outpatient Care** paragraph in the section titled "Network Benefits" on page 84 of the Series 4 Member Handbook is deleted and replaced with the following:

Network Benefits

Outpatient Care – The *copayment* schedule for network outpatient covered services is shown below:

Individual and family therapy, all visits	$15 *copayment*
Medication Management, all visits	$10 *copayment*
Group therapy, all visits	$10 *copayment*
Enrollee Assistance Program, up to 3 visits	No *copayment*

Outpatient care no longer *cross accumulates* with EAP services. (See pages 86–87 of the Series 4 Member Handbook for a full explanation of EAP services.) All outpatient mental health and substance abuse services now have a copay.

Failure to *precertify* outpatient care results in a benefit reduction to the out-of-network benefit level.

Please note that the **Substance Abuse Rehabilitation Incentive Program** *described on page 85 of the Series 4 Member Handbook is no longer available.*

Appendix D: What You Should Know When You Use Non-Massachusetts/Non-PLUS Providers

Appendix D, "What You Should Know When You Use Non-Massachusetts Providers," which was added to the Member Handbook as Appendix D (page 7) in the 2004 Series 4 benefit update, is deleted and replaced with the following:

What You Should Know When You Use Non-Massachusetts/Non-PLUS Providers

This appendix contains important information about how the Commonwealth Indemnity Plan pays for services you receive from health care providers located outside of Massachusetts **that are not PLUS providers**.

Reimbursement to Non-Massachusetts Providers

If you use a non-Massachusetts provider for any reason – including emergency care – you could be subject to balance billing. Balance billing is the practice by health care providers of billing patients for charges that exceed the amount paid by a patient's health plan for services rendered. For example, if your doctor bills your health plan $90 for your office visit and your health plan allows $75 for the office visit, some physicians may balance bill you for the difference of $15.

The following information explains how the Plan reimburses non-Massachusetts providers and how you may be able to manage or avoid balance billing by these providers.

The Plan pays non-Massachusetts providers according to fee schedules that establish the reasonable and customary allowed rates for payment of services. The payments in the fee schedules are consistent with what other plans pay providers. Charges in excess of the fee schedule amounts will not be considered for payment, as they will exceed these allowed amounts. A provider might balance bill you for the difference between the payment made by the Plan according to the fee schedules and the amount the provider charged.

Ways to Avoid Balance Billing

Here are two ways you can manage or even avoid balance billing:

- **Use Massachusetts Providers or PLUS providers in New Hampshire or Rhode Island for Your Health Care Whenever Possible** – If you are planning any elective health care services, or need to schedule a medical or surgical procedure, you should consider using Massachusetts providers for that care whenever possible. These providers are prohibited by Massachusetts law from balance billing members of the Commonwealth Indemnity Plan for amounts above the allowed amounts established in the fee schedules.

The Plan encourages you to plan ahead, scheduling medical care in Massachusetts before you go away, or upon your return. This will guarantee that you don't get balance billed.

- **Discuss the Balance Bill with Your Non-Massachusetts Provider** – Ask your provider to consider accepting the allowed amount from the Plan as payment in full for his or her services. The Commonwealth Indemnity Plan's fee schedules for out-of-state providers are intended to provide adequate compensation for services, usually at a level similar to – and sometimes higher than – what providers are receiving from many other health insurance plans in the area. Additionally, the Plan pays providers promptly; nearly 100 percent of provider claims are paid within 14 days of their receipt.

Using the Plan's Out-of-State Contracted Providers to Avoid Balance Billing

You or your dependent may be able to participate in the Plan's program to help you avoid balance billing if you meet one of the following criteria:

- you or your dependent reside outside of New England temporarily **for more than four consecutive weeks but less than 90 consecutive days of the year** – and receive services from non-Massachusetts providers that are not PLUS providers, or
- you have a student dependent who attends school outside **New England** who receives services from non-Massachusetts providers that are not PLUS providers

This program allows access to contracted providers outside of Massachusetts that you, your dependent or your student dependent can use for health care services, depending on where you, your dependent or your student dependent lives. These providers accept the Plan's fee schedules as payment in full and agree not to balance bill you. For more information on these contracted providers and how to use them, contact the Plan (see information below).

If You Live Temporarily Out-of-State

Please call the Commonwealth Service Center at **(800) 442-9300** to report your new address if:

- you or your dependent plan to reside outside New England for more than four consecutive weeks but less than 90 consecutive days of the year, or
- your student dependent plans to attend school outside New England for more than four consecutive weeks of the year

Or download and complete the temporary change of address form from the Plan's web site at **www.unicare-cip.com** from the "Forms and Documents" web page and mail the form to the Plan.

If you plan to live outside New England for more than 90 consecutive days, please contact the Group Insurance Commission at (617) 727-2310 to discuss alternative health plan options.

For More Information

For additional information about how to avoid being balance billed by non-Massachusetts providers, contact the Commonwealth Service Center at **(800) 442-9300**. You can also e-mail the Plan from its web site at **www.unicare-cip.com**; click on "Contact Us."

Appendix E: List of PLUS Tier 1 and 2 Hospitals

Appendix D: List of PLUS Tier 1 and Tier 2 Hospitals on page 11 of the 2005 Series 4 Benefit Updates and Important Information booklet is deleted and replaced with the following, and renamed Appendix E. The list has been updated to reflect that Caritas Good Samaritan Medical Center in Brockton, MA is now a PLUS Tier 1 hospital, and Jordan Hospital in Plymouth, MA is now a PLUS Tier 2 hospital.

PLUS Plan Tier 1 Hospitals

- Addison Gilbert Hospital, Gloucester
- Anna Jaques Hospital, Newburyport
- Athol Memorial Hospital, Athol
- Baystate Mary Lane Hospital Corporation, Ware
- Baystate Medical Center, Springfield
- Beth Israel Deaconess Medical Center, Boston
- Beth Israel Deaconess Medical Center, Needham
- Beverly Hospital, Beverly
- Cape Cod Hospital, Hyannis
- Caritas Good Samaritan Medical Center, Brockton
- Caritas Norwood Hospital, Norwood
- Charlton Memorial Hospital, Fall River
- Children's Hospital, Boston
- Clinton Hospital, Clinton
- Cooley Dickinson Hospital, Northampton
- Fairview Hospital, Great Barrington
- Franklin Medical Center, Greenfield
- Harrington Memorial Hospital, Southbridge
- Heywood Hospital, Gardner
- Lawrence Memorial Hospital, Medford
- Marlborough Hospital, Marlborough
- Melrose-Wakefield Hospital, Melrose
- MetroWest Medical Center – Framingham Union Campus, Framingham
- MetroWest Medical Center – Leonard Morse Campus, Natick
- Milton Hospital, Milton
- Morton Hospital and Medical Center, Taunton
- Nashoba Valley Medical Center, Ayer
- New England Baptist Hospital, Boston
- Noble Hospital, Westfield
- North Adams Regional Hospital, North Adams
- North Shore Children's Hospital, Salem
- North Shore Medical Center – Salem Campus, Salem
- North Shore Medical Center – Union Campus, Lynn
- Quincy Medical Center, Quincy
- Saints Memorial Medical Center, Lowell
- St. Luke's Hospital, New Bedford
- Tobey Hospital, Wareham
- Winchester Hospital, Winchester
- Wing Memorial Hospital and Medical Centers, Palmer

PLUS Plan Tier 2 Hospitals

- Berkshire Medical Center, Pittsfield
- Boston Medical Center, Boston
- Brigham and Women's Hospital, Boston
- Cambridge Hospital, Cambridge
- Caritas Carney Hospital, Boston
- Caritas Holy Family Medical Center, Methuen
- Caritas St. Elizabeth's Medical Center, Boston
- Dana-Farber Cancer Institute, Boston
- Falmouth Hospital, Falmouth
- Faulkner Hospital, Boston
- HealthAlliance Hospital, Burbank
- HealthAlliance Hospital, Leominster
- Hillcrest Hospital, Pittsfield
- Jordan Hospital, Plymouth
- Lahey Clinic, Burlington
- Lawrence General Hospital, Lawrence
- Lowell General Hospital, Lowell
- Mass Eye and Ear Infirmary, Boston
- Massachusetts General Hospital, Boston
- Mount Auburn Hospital, Cambridge
- Newton-Wellesley Hospital, Newton
- Somerville Hospital, Somerville
- South Shore Hospital, South Weymouth
- St. Anne's Hospital, Fall River
- The Floating Hospital for Children at Tufts–New England Medical Center, Boston
- Tufts–New England Medical Center, Boston
- UMass Memorial Medical Center – Memorial Campus, Worcester
- UMass Memorial Medical Center – University Campus, Worcester
- Whidden Memorial Hospital, Everett

Appendix F: Designated Hospitals for Select Complex Inpatient Procedures and High-Risk Maternity Care

Appendix E: Designated Hospitals for Select Complex Inpatient Procedures and High-Risk Maternity Care on page 12 of the 2005 Series 4 benefit update is deleted and replaced with the following, and renamed Appendix F.

There is a $200 deductible per calendar quarter for inpatient care at all PLUS acute care hospitals located in Massachusetts that are designated as Tier 1 in Appendix E on page 16 of this update. The PLUS Plan also provides access to the following additional hospitals for certain complex procedures at the $200 deductible level, as indicated in the chart below.

	Brigham and Women's Hospital	Caritas St. Elizabeth's Medical Center	Lahey Clinic	Massachusetts General	Mount Auburn Hospital	South Shore Hospital	Tufts-New England Medical Center	UMass Memorial Medical Center
Abdominal Aortic Aneurysm Repair*	X		X	X				X
Cardiac Valve Procedures	X		X	X				X
Coronary Artery Bypass*	X		X	X			X	
Discectomy & Laminectomy	X		X	X				X
Esophagectomy*	X		X	X				
High Risk Deliveries & Neonatal ICUs*	X			X		X	X	X
Hip Replacement	X		X	X				X
Knee Replacement	X		X	X				X
Pancreatic Resection*	X		X	X			X	X
Percutaneous Coronary Intervention*	X	X	X	X	X		X	X
Spinal Fusion	X		X	X				X

* These procedures have been designated by the Leapfrog Group for Patient Safety as complex procedures that studies indicate are most safely performed at hospitals that meet the following criteria: 1) they have significant experience in performing the procedure, and 2) they comply with specific clinical practices established by the Leapfrog Group.

Notice of Group Insurance Commission Privacy Practices

The following information is added to the Series 4 Member Handbook as Appendix G.

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at www.mass.gov/gic.

Required and Permitted Uses and Disclosures

We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make *without* your authorization:

Payment Activities – The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations – The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

Other Permitted Uses and Disclosures – The GIC may use and share PHI as follows:

- to resolve complaints or inquiries made on your behalf (such as appeals)
- to verify agency and plan performance (such as audits)
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement)
- for judicial and administrative proceedings (such as in response to a court order)
- for research studies that meet all privacy requirements
- to tell you about new or changed benefits and services or health care choices

Required Disclosures – The GIC **must** use and share your PHI when requested by you or someone who has the legal right to act for you (your Personal Representative); when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations that Assist Us – In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your Rights

You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. *You must ask for this in writing.* Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. *You must ask for this in writing, along with a reason for your request.* If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
- Get a listing of those with whom the GIC shares your PHI. *You must ask for this in writing.* The list will *not* include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research.
- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. *You must ask for this in writing.* Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. *You must tell us in writing that you are in danger, and where to send communications.*
- Receive a separate paper copy of this notice upon request (an electronic version of this notice is on our web site at www.mass.gov/gic).

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 1 or TTY for the deaf and hard of hearing at (617) 227-8583.

Your Prescription Drug Coverage and Medicare

The following information is added to the Series 4 Member Handbook as Appendix H.

Important Notice
About Your Prescription Drug Coverage and Medicare

The Centers for Medicare Services requires that this *NOTICE OF CREDITABLE COVERAGE* be sent to you. Please read it carefully and keep it where you can find it.

Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare. This notice:

- applies to you only if you are currently Medicare-eligible or if you should become Medicare-eligible within the coming year;
- provides information about your GIC-sponsored drug coverage and the new Medicare drug coverage to help you decide whether to enroll in one of the Medicare drug plans;
- explains your options; and
- tells you where to find more information to help you make a decision.

FOR MOST PEOPLE, THE DRUG COVERAGE YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE NEW MEDICARE DRUG PLANS', SO YOU DO NOT NEED TO PAY FOR ADDITIONAL DRUG COVERAGE.

The New Medicare Drug Plans

The new Medicare prescription drug benefit, also known as Medicare Part D, will be offered through various health plans and other organizations. All Medicare prescription drug plans will provide at least the standard level of coverage set by Medicare; some plans might also offer more coverage for a higher monthly premium. In order to decide whether to join a Medicare drug plan, compare which drugs the Medicare drug plans in your area cover and their costs, and consider the following information:

- **You can continue to receive prescription drug coverage through your GIC health plan rather than joining a new Medicare drug plan. Most GIC members do not need to do anything and should not enroll in a Medicare drug plan.**
- Your GIC drug coverage is part of your GIC health insurance, which pays for your health expenses as well as your prescription drugs.
- If you elect Medicare drug coverage, you will have to pay for the entire Medicare drug coverage premium.
- If you should enroll in a Medicare drug plan while you are also enrolled in Fallon *Senior Plan*, Harvard Pilgrim Health Care *First Seniority* or Tufts Health Plan *Medicare Preferred* (formerly *Secure Horizons)*, you will lose your GIC-sponsored health plan coverage under current Medicare rules.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available on-line at www.socialsecurity.gov, or by phone at (800) 772-1213 (TTY: (800) 325-0778).

Creditable Coverage Information

Your GIC prescription drug coverage is, on average, expected to pay out at least as much as the standard Medicare drug coverage will pay. This means that your GIC coverage is "Creditable Coverage." You may need to show this notice to the Social Security Administration as proof that you have Creditable Coverage (to avoid paying a premium penalty), if you later enroll in a Medicare drug plan.

If you drop or lose your GIC coverage and do not enroll in a Medicare prescription drug plan soon after your GIC coverage ends, you could be required to pay a premium penalty for Medicare drug coverage when you do enroll. After May 15, 2006, if your GIC coverage ends and you delay 63 days or longer to enroll in Medicare drug coverage, you will have to pay a premium penalty for as long as you have Medicare drug coverage. Your monthly Medicare drug premium will go up at least 1 percent per month for every month after May 15, 2006 that you do not have creditable drug coverage. In addition, you may have to wait until the next Medicare annual enrollment period to enroll.

For more information about this notice or your prescription drug coverage options:

- Call (800) MEDICARE – (800) 633-4227. TTY users should call (877) 486-2048.
- Visit www.medicare.gov.
- Call the Group Insurance Commission at (617) 727-2310.

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The following information is added to the Series 4 Member Handbook as Appendix I.

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents.
- If you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed.
- Service members who elect to continue their GIC health plan coverage are required to pay the employee share for such coverage.
- USERRA coverage runs concurrently with COBRA and other state continuation coverage.
- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at (866) 4-USA-DOL or visit its web site at www.dol.gov/vets. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information, please contact the Group Insurance Commission.

Commonwealth
Indemnity Plan
Administered by UNICARE
PO Box 9016
Andover, MA 01810-0916

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Important Information Enclosed
Please Read